********** City of El Paso Department of Public Health **********

(PLEASE PRINT)

Last Name **First Name** **Middle** **Age**

Gender: M/ F **Race:** **Birth Date** ***MM/DD/YY***

Address **City** **State** **Zip** **County** **Telephone**

Mother's Name **Mother's Maiden Name** **Mother's DOB** ***MM/DD/YY*** **Father's Name**

TVFC ELIGIBILITY

- ☐ Enrolled in Medicaid
- ☐ No Health Insurance
- ☐ American Indian or Alaskan Native
- ☐ Patient who receives benefits from CHIP
- ☐ Underinsured (has private health insurance but coverage does not include vaccines; insurance covers only selected vaccines; insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured)
- ☐ Has private insurance that covers vaccines (**not eligible**)

INSURANCE

Does the patient receive any of the following:

Medicaid: Yes No If YES, # _____

Medicare: Yes No If YES, #_____

CHIP: Yes No If YES, #_____

WIC: Yes No

MEDICAL HISTORY

1. Is Child/Adult Sick Today?..... Yes No
2. Does Child/Adult have allergies to medications, food and/or vaccine?..... Yes No
3. Has Child/Adult had a serious reaction to a vaccine?..... Yes No
4. Does/Has Child/Adult have health problems like asthma, lung, heart, kidney disease, cancer, AIDS and/or any other health problem?..... Yes No
5. Has Child/Adult had a seizure or a brain disorder?..... Yes No
6. Has Child/Adult taken cortisone, prednisone, or other steroids, x-rays or anticancer medication in the past 3mths?..... Yes No
7. Has Child/Adult received a transfusion of blood or blood product or been given immune (gamma) globulin in the past year?..... Yes No
8. Is the Teen/Adult pregnant or is there a chance she could become pregnant during the next month?..... Yes No
9. Has the Child/Adult had vaccines/shots in last 4 weeks?..... Yes No
10. Has the Child/Adult had Chickenpox, if so when?..... Yes No

If YES, Month/Day/Year _____

PARENT/GUARDIAN CONSENT

I received or was offered a copy of the Vaccine Information Statement (VIS) for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had opportunity to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

I acknowledge that I have received a copy of the
******"Notice of Privacy Practices of the City of El Paso Department Public Health" *****

Signature: _____ **Relationship to the Patient: _____** **Date: _____**

*****Clinic Use Only *****

I certify any services for CHIP members will be billed to CHIP □ Yes □ No

TVFC Eligible □ Yes □ No **Clerk Initials:_____**

Date Given	Vaccine Given	Mfg	VIS Date	Lot #	Site Used	Adm. Initials
	Pediarix *6wk-6y Dtap/HepB/IPV*	GSK				
	KINRIX *4-6y DTaP/IPV*	GSK				
	Pentacel *6wk-5y Dtap-IPV/HIB*	Sanofi				
	DTaP *6wk-6y*	GSK Sanofi				
	HEP A *1-18y*	GSK Merck				
	HEP B *0-18y*	GSK Merck				
	PCV-13 *<5y*	Wyeth				
	HIB *<5y*	Sanofi				
	Rotavirus *6-32wks*	GSK Merck				
	IPV *6wk-18y*	Sanofi				
	ProQuad *1-12y MMR/VAR*	Merck				
	MMR *1y>*	Merck				
	Varicella *1y>*	Merck				
	Pedi Flu *<3yr*	Sanofi				
	Flumist *2-18y*	Medimmune				
	Flu *>3yr*	Sanofi				
	Hep A 19>	GSK				
	Hep B *20>*	Merck				
	Twinrix *18>*	GSK				
	HPV *9-26y*	GSK Merck				
	MCV4 *11-55y*	Sanofi				
	Tdap *10-64y*	GSK				
	Adacel 11-64y	Sanofi				
	Td *7-10y-65>*	Sanofi				
	PNEUMO-23 *ADULT*					
	***Zoste**r 60>*	Merck				
	PPD					